Section: Modern PPT practice

CONCEPTUALIZATION OF DEPRESSIVE DISORDERS AND THEIR TREATMENT IN POSITIVE AND TRANSCULTURAL PSYCHOTHERAPY (PART 2)

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Abstract

In this article, the author attempts to conceptualize the treatment of depressive disorders through the lens of positive and transcultural psychotherapy (PPT), referring to the main tenets of this approach and his own experience as a psychotherapist and psychiatrist. The most important aspects are included here to structure and operationalize the psychotherapy of depression. Relational aspects and differential analysis of symptoms, psychodynamic conflicts, and early symptomatic experiences are discussed.

Keywords: psychotherapy of depression, therapeutic relationship, psychodynamic conflicts in depression, differential analysis, Positive Psychotherapy

Introduction

Given the multifactorial etiology of depressive disorders and their varied course, comprehensive treatment is always worth considering (Freeman, 2009; Bortolotti et al., 2009; Cipriani et al., 2009). Comparative studies indicate that in many cases, the most effective treatment is a combination treatment that includes psychotherapy and pharmacotherapy (Cuijpers et. a, 2009a; Cuijpers et al., 2009b). Among the numerous schools of psychotherapy with operationalized treatment, the cognitive-behavioral approach (Dobson et al., 2008; Haarhoff et al., 2011; Huisman et al., 2011) stands out, thanks largely to the work of Aron Beck (Beck, 2011; Beck et al., 1996), and rational behavior therapy thanks to the merits of its creator Albert Ellis (Ellis, 2005).

It seems reasonable, therefore, to attempt to conceptualize psychotherapeutic interventions with depressive patients in PPT. This method is an integrative (psychodynamic-humanistic) approach and is distinguished by the specificity of its theory and applied practices (Peseschkian, Remmers, 2020).

By design, this article will omit psychiatric-medical treatment methods and focus exclusively on psychological interactions. Due to the vastness of the topic, some of the issues will be discussed more extensively, and others will be discussed briefly.

Methodology

2.1. Therapeutic relationship in the treatment of depression - three stages of interaction

Given the dependency tendencies present in depressive patients and the consequent need to support them in healthy separation and autonomy, it is worth considering several basic issues when establishing and building a therapeutic relationship. To understand these,

reference will be made to the interaction model (Peseschkian, 1987).

INTERACTION MODEL

The interaction model includes three stages: attachment, differentiation, and detachment. These stages will now be briefly discussed in relation to the specifics of the therapist-depressive-patient relationship.

1. Attachment phase

The attachment phase, in the case of depressive patients, should last relatively longer and should include, as far as possible, defining the patient's bonding needs and describing them in terms of easily defined primary capabilities. Particularly noteworthy here is the ideal dimension of capabilities, e.g., *What is ideal love, acceptance, trust, etc. for you?* Questions of this kind allow you to identify expectations of the therapeutic alliance and overall therapeutic goals. In the attachment phase, it is possible to allude to the anticipated detachment phase that will take place when the essential therapeutic goals have been realized. This makes it possible to assess possible difficulties in the patient's separation from the therapist and prevent them in good time.

2. The differentiation phase

In the differentiation phase, more activity is expected from the patient, who has already built and strengthened a therapeutic alliance with his therapist. However, it is advisable to maintain an understanding and accepting attitude in the face of continuing tendencies toward withdrawal, passivity, and avoidance of responsibility. Such attitudes should be interpreted to identify the fears behind them and support the patient to regain a renewed grip on his life.

3. Detachment phase

The detachment phase should occur at the stage of accomplishing therapy's main goals and the therapeutic relationship's intended resolution. It allows the patient to recognize any dependency tendencies that may persist despite the fulfillment of his/her assumptions about the contracted goals of therapy. At this final stage, the patient's desire for attachment in interpersonal and personal relationships and the simultaneous need to maintain autonomy should remain balanced.

2.2. Psychotherapy of depression and neurobiological conditions

Regarding depressive disorders, abnormalities in the cooperation of the limbic system and prefrontal cortex of the brain deserve special attention (Brody et al., 2001). Studies show that people prone to developing depression exhibit an increased sensitivity to the limbic system, particularly the amygdala, which has a genetic basis (MacQueen et al., 2003; Hamilton at. al., 2008); as a result of this hypersensitivity, these individuals react with excessive arousal of negative affects in response to stressful situations. This state of emotional arousal abolishes the inhibitory function of the prefrontal cortex and negative affects cause it to "flood." As a result, depressed individuals have a reduced capacity for strategic-operational thinking, and their ruminations are dominated by so-called ruminations, i.e., tendencies to unproductively dwell on unsuccessful events and trigger feelings of guilt. This state is undesirable from the patient's perspective and that of the psychotherapist because it is difficult for the patient to use the newly provided knowledge and change rigid patterns of thinking, reacting, and behavior. For this reason, various forms of interventions and therapeutic recommendations that help neutralize negative affects and restore neurophysiological balance within the limbic system and prefrontal cortex can be useful to begin with.

Positive psychotherapists, given the specificity of the phenomena described here, readily reach for certain tools to expand the perceptual-cognitive capabilities of patients. Such interventions include:

(1.) Positive reframing of disease symptoms;

(2.) Exploring the function and meaning of disease symptoms;

(3.) Increasing the patient's resilience;

(4.) Exploring and strengthening the patient's mental resources;

(5.) Exercising mindfulness and inducing positive affect.

2.3. The therapeutic process and therapeutic interventions in the treatment of depression

In PPT, in therapeutic work with depressive patients, we deal with differential analysis in three stages (Ciesielski, 2024) (Tab. 1):

A. symptoms;

B. conflicts;

C. source symptomatic experiences.

Table 1.
Levels of therapeutic interventions in the treatment of depression

LEVELS OF THERAPEUTIC INTERVENTIONS in PPT	differential analysis
A. Symptoms	
B. Psychodynamic conflicts	
C. Target symptomatic experiences	

Discussion

3.1. Depressive symptoms - differential analysis

Depressive symptoms in the context of the patient's life

At PPT, we believe in the wisdom of the messages that disease symptoms carry, even those as painful as depressive symptoms. To discover this wisdom, it is necessary to broaden and deepen the patient's perspective to learn the hidden meaning of the symptoms in the broader context of his or her life. To this end:

(1.) We explore the relationships between depression and the major dimensions of the patient's Balance Model.

(2.) In addition, we encourage the patient to externalize depression as a whole or its selected symptoms and, through this, weaken his or her identification with the illness.

(3.) Then, from the position of an outside observer, the patient examines how depression has affected major areas of his life. Of interest at this stage seems to be the search for what visible changes depression causes in the distribution of the patient's life energy. The answer to this question is often a clue as to what unconscious needs the patient may be compensating for due to the presence of depression.

According to Beck's triad (Beck, 1967), depressive patients used to think that their symptoms:

(1.) Are present in every area of their lives (ubiquitous);

(2.) They will last indefinitely (timeless);

(3.) Are beyond their control (loss of influence).

On the other hand, N. Peseschkian makes us realize that assessing the impact of depressive symptoms on a patient's quality of life in the Balance Model (BM) can challenge these implicit assumptions. The question - *In which of the dimensions in your BM does depression wreak the most havoc?* - implicates that there are dimensions in which depression makes its mark to a lesser degree. One can assume that it is in these areas that the patient's hidden resources make him more resistant to the negative influences of the disease. In the following, it seems reasonable to ask:

EXAMPLES

a) Through what do you manage to defend yourself more effectively against depression in terms of your care of your body and senses?

b) How is it that depression does not prevent you from fulfilling your professional duties, even though it deprives you of energy when you spend time at home with your family in the evenings?

This kind of inquiry implicitly challenges the assumption that depression is ubiquitous in a patient's life, or it points to the presence of mental resources that he or she had previously underestimated.

Regarding the timeless nature of the occurrence of disease symptoms, in PPT, too, there are ways of dealing with them that enable the patient to place the end to his or her suffering in time and inspire hope for recovery. A helpful way to do this is to encourage the patient to create a BM energy distribution that is optimal for him or her in the near or distant future. Such action assumes that if the signals of depression are heeded in time, the patient will be able to free himself from it and manage his life more effectively. Careful design of future BM has the advantage of marking an end, in terms of the existence of the disease, and at the same time, allowing the patient to regain a sense of influence and control over his own life.

Positive reframing of depressive symptoms

In the subjective experience of illness, almost every patient has the belief that their symptoms are solely a source of suffering and cause increased dysfunction. PPT takes a broader perspective in this regard and, while showing respect for the patient's emotional suffering, on the one hand, seeks to see in the illness, on the other hand, the developmental potential and the desire to improve the quality of life. Positive psychotherapists assume that to ultimately free oneself from the influence of the disease; it is necessary to understand its functions and

hidden meanings. For this reason, working at the level of depressive symptoms, they seek to uncover their familial, social, and cultural context. As we know from previous descriptions, in some cultural circles, depression provides care and attention from closer and extended family (capabilities: contact, closeness, bonding), while in others, on the contrary, it is a way to withdraw from social contacts and previous commitments to be with oneself alone in isolation (capabilities: internal cohesion, contact with one's Self). Thus, as can be seen, the functions of depression on an individual and collective level can be different. Their recognition, differentiation, and ultimate acceptance create opportunities to find alternative ways to meet one's own needs and those of others. In PPT, we use positive reframing, which involves attributing constructive connotations to certain symptoms. Through such therapeutic interventions, patients find a new sense of their suffering and the roles that come with being a sick person.

CLINICAL ILLUSTRATION. PART 1

Ms. Kathrin, 19 years old, was regarded as a child prodigy from early childhood. She manifested numerous talents, and learning came easily to her. Her abilities stood out from those of her peers in the sciences and humanities. In addition, she was very ambitious. Everything indicated that she would be "doomed to success." To the expectations of her parents and teachers, she invested all her time and energy in her studies. However, the price she paid was a lack of friends and extracurricular activities. Her parents actively sought prestige and social status. Her father was a well-known attorney, and her mother was a university teacher. Her father devalued his wife's professional achievements, believing that professional success was measured by salary. Meanwhile, she responded to his accusations by writing more academic publications that strengthened her position at the university.

A well-known family motto was: Don't waste time playing; take care of your studies.

Everything in the family would have gone well if it had not been for the fact that two months before matriculation, Ms. Kathrin's mood deteriorated noticeably. She lost her self-confidence and sense of direction going forward. She stopped enjoying everything that had previously given her pleasure and, worst of all, lost motivation to study. She finally mobilized just before her high school graduation and successfully passed her final exams. As a result, she obtained an index to her desired university, the law faculty.

However, before the final session of her freshman year, the situation repeated itself, and Ms. Kathrin. developed a second depressive episode, this time requiring therapeutic intervention. She complained of depression, constant fatigue, lack of motivation to do things, lowered self-esteem, and sleep disturbances. To her shame, she admitted that to force herself to study at home, she would cut her body with her fingernails and tear her wounds.

As can easily be seen in the case of both depressive episodes, the contribution of pre-examination stress and its impact on Ms. Kathrin's self-esteem was evident. One can conclude that the pursuit of success in the academic sphere was her only source of positive self-esteem. At the same time, she was overly self-critical and assumed that those close to her expected a lot from her and that she might not be able to live up to those expectations.

Her personality was characterized by responsibility, perfectionism, ambition, and self-discipline.

At the beginning of psychotherapy, Ms. Kathrin perceived her depression as something extremely negative. However, after several meetings, when asked about the positive message of depression, she stated, to her surprise: Depression tells me to *stop... take care of yourself... give yourself something nice... pay attention to what is happening to you right now... look around you.* In subsequent sessions, she and her therapist formulated several hypotheses about the function of depression in her life. I list them below:

- *Depression makes me realize how much I try to be loyal to family traditions and values;*
- *Depression shows me how much I want to be an independent woman in my life, just like my mother;*
- *Perhaps depression is planting doubt in me about whether I want to follow my father's career path.*
- *Perhaps I am learning from the depression that I have overinvested in education while neglecting other things that are important to me.*
- *Ms. Kathrin. also made some positive reframing of her depressive state. Here they are:*
- *Thanks to depression, I am reaching my longings that have been suppressed for years.*
- *Depression helps me experience care and kindness from colleagues.*
- *Depression allows me to be closer to my body and its needs, which I had previously neglected.*

After initial insights into the function and meaning of depression, Ms. Kathrin. engaged in further discovery of the impact of the illness symptoms of depression on the various dimensions of her Balance Model. She developed initial strategies for developing the most neglected areas (body and social contacts). Changes in these areas stabilized her sense of self-esteem and improved contact with herself and her significant others.

3.2. Psychodynamic conflicts - differential analysis

As mentioned earlier, in PPT terms, we consider emotional and mental disorders as a form of expression of unresolved internal conflicts. In other words, disease symptoms indicate the presence of active intrapsychic processes, i.e., dysfunctional patterns of perceiving, experiencing, and reacting. This means that the patterns adapted in childhood to meet basic biological-emotional needs have ceased to fulfill their functions. In the case of depression, we speak of the ineffectiveness of actions taken in response to new environmental stimuli (actual conflict). Repeated attempts to apply strategies inadequate to the situation (inner conflict) give rise to high levels of frustration and a loss of influence over one's life. This is one of the most common criteria for the diagnosis of depressive disorders. Under these circumstances, identifying adaptive patterns (basic conflicts) that have become too rigid and overgeneralized becomes indispensable in the diagnostic and therapeutic process. Identifying and discovering their sources and recognizing their previous functions allow new ways of satisfying patient's needs and a related behavior change.

According to PPT concepts, people prone to depression may present quite diverse adaptive patterns (basic conflicts) that underlie their psychopathology. What characterizes them is excessive rigidity and generalization. This raises the question of whether there are patterns of basic conflict that predispose to or sustain depression. Observations and the author's clinical experience indicate the presence of such a pattern and the associated inner conflict.

The risks associated with developing depression were addressed by Beck (1983) and Blatt and Luyten (1982). The first author referred to the concepts of sociotropy and autonomy, and the other two introduced analogous terms, i.e., dependence and autocritical perfectionism. According to the researchers, sociotropy/dependence and autonomy/self-critical perfectionism describe how the self is organized in an individual's life and how his sense of self-worth is formed. The concepts described here are generally consistent with the author's observations, so it is worth paying a little more attention to them. It turns out that people prone to depression depend too much on the approval of people important to them for their sense of value and, at the same time, are overly focused on the need for achievement to gain their autonomy. Such a situation creates an internal conflict between the need for attachment and the need for independence. The authors believe that the development and self-organization of the "self" proceed properly if two opposing tendencies remain in balance. The first is attachment, which tends to lead to mature and mutually satisfying interpersonal relationships, and the second is autonomy through self-determination, which promotes the formation of a stable, realistic, and essentially positive sense of self. Empirical research shows that the unfulfilled need for recognition and acceptance (attachment) in people prone to depression causes them to fear not meeting these expectations and results in increased distance in close relationships. Fonegy (2002) believes that this further promotes the occurrence of hyper-vigilance to rejection, which leads to constant self-doubt and hinders the development of a sense of autonomy, integrity, and agency. The same author reports that self-critical, perfectionist individuals tend to elicit criticism and disapproval from others because of their exorbitant standards and overly demanding attitudes. In this way, the social environment tends to confirm dependents' fears of rejection and fears of disapproval of self-critical individuals. It can be said that an implicit principle is at work here: *We cannot satisfy your emotional hunger anyway, or you will never satisfy my emotional hunger anyway.*

Self-critical individuals show excessive vigilance when it comes to their failures. This

usually leads to increased self-doubt and often to a loss of self-esteem. Such feelings and fantasies make it very difficult to build a positive self-image. These findings (McGonagle, Kessler, 1990; Meyer et al., 2001) correspond with mainstream models of depression, which draw attention to the increased sensitivity to stressful situations in people prone to it.

On the other hand, the pursuit of autonomy in such individuals is often the result of their identification with the high demands of attachment figures or is a defensive compensation for their understated sense of worth. This is expressed in an exaggerated focus on achievement, with excessive mental and/or physical energy commitment. One may assume that such a propensity for sacrifice essentially serves the purpose of seeking recognition and approval. However, in this case, self-critical perfectionism causes the individual to remain constantly dissatisfied with himself or herself despite the constant efforts, sometimes on the verge of exhaustion. In this case, the principle is revealed: *Whatever I do and achieve, I won't be satisfied with myself anyway, or Whatever I do and whatever I achieve, people close to me won't be satisfied with me anyway.*

The most common pattern of basic conflict (adaptive schema) of people predisposed to depression, described here, is shown in Fig. 1.

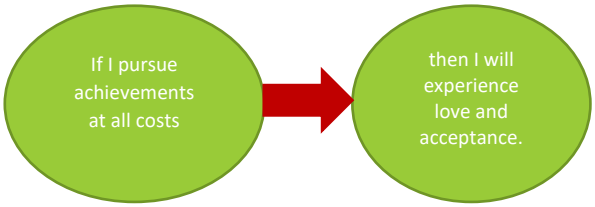

Figure 1. Predisposition to depression - the pattern of underlying conflict in PPT

In contrast, the nature of the internal conflict in this case is illustrated in Fig. 2

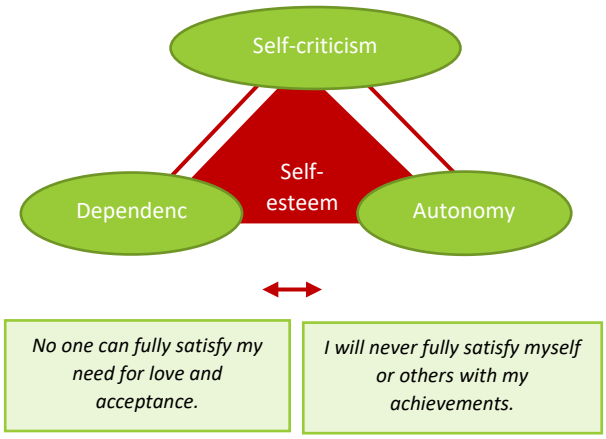

Figure 2. Predisposition to depression - internal conflict model (R. Ciesielski)

The internal conflict model proposed here that characterizes people with a predisposition to depression and those experiencing depression implies certain directions for therapeutic work in PPT.

One of the key therapeutic challenges at the stage of differential analysis of psychodynamic conflicts in people with depression is to work with self-esteem. In PPT, using the Structural Model of Personality (OPD 2) (Cierpka et al., 2007), we refer accordingly to four dimensions that regulate the sense of value in depressive patients (Figure 3) and define the related directions of therapeutic work.

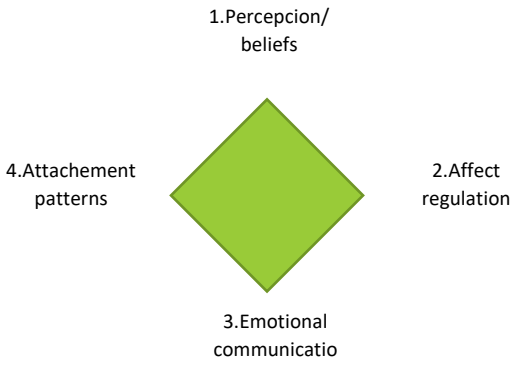

Figure 3. Dimensions of self-esteem in depressive patients

Directions of work with self-esteem in depressive patients

(1.) PERCEPTION AND BELIEFS

Depressive patients' inadequate and undervalued sense of worth often stems from their cognitive distortions and false assumptions about themselves. They repeatedly depreciate

their achievements and their life achievements based on misconceptions.

The main lines of therapeutic action in this case include:

(a) working with the Ideal Self and the Real Self;

(b) analyzing one's projections attributed to the social environment;

c) separating one's self-perception from that of others (self-image vs. social image);

(d) differentiating social perceptions of self (multidimensionality of perceptions);

(e) reflecting oneself against the therapist (social mirror).

(2.) REGULATION OF AFFECT

The destructive nature of negative affects occurring in depressive patients and related thought ruminations has been mentioned earlier. As far as working toward improving their sense of self-worth is concerned, the following are of importance:

(a) positive reframing of the symptoms of illness;

(b) discovering the function and meaning of symptoms;

(c) affirmations to induce positive affect;

(d) mindfulness and self-hypnosis techniques to help ground oneself in a safe and friendly place.

(3.) EMOTIONAL COMMUNICATION

Emotional communication describes how the patient monologues with himself at various important moments in his life. His comments on various events can be supportive and empowering or depreciating and devaluing. In depressive patients, the latter situation usually takes place. We say that their inner critic is very harsh to them. So, not coincidentally, the work on improving self-esteem will relate largely to the metacomments that occur in them and include:

(a) calibration of the internal critic (working with sound submodalities like voice intonation, intensity, source, direction, amplitude, etc.);

(b) dialogue of internal and external polemical voices;

(c) seeking and recreating positive past experiences (activating psychological resources) and interpreting and commenting on them;

(d) internalizing the voice of a mentor, guardian, or benevolent life guide.

(4.) ATTACHMENT PATTERNS

Research indicates that people suffering from depressive disorders often experience relational trauma, abuse, and parental neglect during childhood. This may have resulted in the development of an insecure attachment style and deprivation of their basic needs for security and psychological comfort. Moreover, it may have resulted in a lack of confidence in their judgment of events and ability to understand social situations. In PPT, regarding such deficits related to the sense of worth in depressed patients, we propose, among other things:

(a) identifying the patient's dominant attachment style;

(b) creating corrective experiences in the therapeutic relationship (enhancing the development of actual capabilities that are latent);

(c) active modeling of secure attachment style by the therapist (PPT interaction model);

(d) work in the mentalization of self and others.

All these therapeutic interactions, with the idea of improving and making self-esteem more adequate in depressive patients, simultaneously create experiences that constitute alternative sources of knowledge about themselves. This knowledge will provide a new frame of reference for further work in source symptomatic experiences.

CLINICAL ILLUSTRATION. PART 2

As mentioned earlier, Ms. Kathrin adopted a certain model of functioning in childhood that gratified her needs for acceptance, recognition, and contact. By striving for success in the academic sphere, she instilled a sense of pride in her parents and gained their attention. This behavior pattern worked particularly well when her grandmother was raising her due to her parents' excessive work responsibilities. Thus, as can be seen, she depended on good grades and praise from her parents and teachers for her sense of worth (basic conflict). However, in her dwellings, adults were too demanding and critical, so she persisted in her efforts to win their favor. At the same time, she began to set higher and higher expectations for herself. In this way, she fell into the trap of being unable to fully satisfy herself or others. In this situation, her self-worth was fragile and strengthened too one-sidedly. At a moment of increased stress (high school and semester exams), and given the patient's personality predispositions, i.e., her perfectionism and low frustration threshold, the aforementioned pattern of basic conflict was

bound to break down sooner or later (inner conflict). As a result, her desire for closeness (contact) remained unsatisfied. What's worse, there was a growing distance in her relationships with people close to her, as these people subconsciously felt that they were unable to respond adequately to her needs. At the same time, Ms. Kathrin's desire to gain autonomy through academic success also could not be fulfilled due to the deterioration of her academic performance. The prolonged internal conflict in proximity-independence (contact-success) resulted in Ms. Kathrin's development of depressive symptoms, which became a temporary solution to the conflict situation for her. This was because they could serve to satisfy her regressive dependency needs and postpone her plans for autonomy.

At this stage of psychotherapy, Ms. Kathrin learned the specifics of her basic conflict (currently a disadaptive pattern) and its destructive impact on her sense of self-efficacy and self-esteem. Subsequently, she began to adopt new alternative ways of satisfying such needs as recognition, acceptance, and admiration and learned to show care and kindness to herself. Eventually, she took steps to strengthen or transform her own social self, which she recognized as too "template-like" and unattractive. Therapeutic work related to the patient's emotional communication also produced satisfactory results. As a result, she "tamed" her inner critic and called up an "inner ally" whom she called a "tender and attentive guide."

3.3. Target symptomatic experiences - differential analysis

As we know, the human brain stores all previously acquired experiences, constituting personalized knowledge of the world. The thing is that some of these memories promote a distorted picture of reality and become a source of mental suffering. In PPT, we talk about so-called prior (target) symptomatic experiences. Clinical practice shows that, in many cases, the links between childhood experiences and later-occurring disease symptoms are not so obvious. An analogous situation occurs in patients with depression. In psychotherapy for depressive disorders, the main goal becomes for the patient to reach the so-called target memories stored in the unconscious and eventually change their original records at the neuronal level. This will ultimately result in the extinction of the unpleasant symptoms of the disease. This phase of treatment in PPT is called differential analysis in symptomatic experience. The way to reach the significant events of the past is called affective and neuronal pacing. Affective pacing empathetically reinforces an emotional resonance in the patient, the so-called affective bridge, which connects memories with similar content. At the neuronal level, this means that specific emotions evoked in therapy cause stimulation of selected neuronal pathways that store target experiences underlying disease symptoms. An example of such an affect-enhancing pathway in depressive patients might be sadness associated with rejection, exclusion, loneliness or guilt, or feelings of shame or ridicule. N. Peseschkian (1987) sought, among other things, the genesis of depressive experiences by exploring patients' main concepts of self and environment, i.e.

(a) the concept of self;
(b) the concept of partnership;
(c) the concept of social relationships;
(d) the concept of the world.

He hypothesized that significant distortions in terms of a selected one of these concepts have their origins in the past and can trigger and sustain depressive symptoms. He encouraged patients to successively reconstruct from memory the landmark and critical events of their lives so that they could relive them and analyze them in depth. He tried to work with patients to find similar content in them (see actual capabilities) and recognize either the developmental potential present in them (see active capabilities) or the inhibition of that potential (see latent capabilities). Differential analysis at this stage involves extracting from among the many possible events the earliest ones that are in vivid emotional resonance with the patient's current depressive experience. The experiences associated with these form the matrix for memory and are replicated at later stages of life, resulting in depressive disorders. Identified and recalled experiences of this type can be subjected to differentiation, which will allow the patient to separate his associations from sensory perception, bodily reactions, etc., and eventually discover his assumptions and emotional truths associated with them. Usually, this process is accompanied by clear insights and a search for alternative explanations and possibilities for new constructive experiences. Positive therapists try at this stage to create the

optimum conditions for a so-called transformative experience, in which the patient can challenge his previous truths, causing his current dysfunctions, and adapt useful knowledge for himself or herself. He or she has accumulated this knowledge successively in earlier phases of psychotherapy within the sessions (relational experiences) and outside them (experiments and spontaneous experiences), and in the present moment, he can integrate it and change his previous records at the neuronal level. The disease symptoms begin to subside when integrating new or early acquired knowledge is complete.

CLINICAL ILLUSTRATION. PART 3

Over time, Ms. Kathrin became increasingly aware of her fear of failure and not meeting her ideals. She was surprised to discover that she radicalizes her position so much and that the smallest failures or related fantasies cause her strong feelings of rejection and loneliness. Encouraged to carefully experience this feeling of loneliness once again in the presence of a therapist (affective bridge), she gradually recalled memories that corresponded with this feeling. She regretted that there had been many such episodes in her life when she had felt unnoticed, unappreciated, and even abandoned. She first recalled the moment of her grandmother's death and realized that her grandmother was, at times, closer to her than her mother. Later, she quickly linked the facts and returned to when her parents gave her to her grandparents to raise to pursue their careers. The patient discovered that this was the time when she strenuously fantasized about how to regain her parents' love. As a child, she intuitively put some facts together rather quickly and saw that she could win their admiration and appreciation by studying hard and getting the best grades in school. As with her father, the prospect of a career as a lawyer aroused a lot of enthusiasm in her closer and more distant family. As a result, she abandoned all pleasures and devoted herself entirely to her studies. However, on an unconscious level, she was constantly accompanied by anxiety, which seemed to say: *What if I fail? What then?* Trying to tame her anxieties, she pursued success with even greater determination.

When Ms. Kathrin analyzed the period of her life when she lived with her grandparents (age 7-9), she questioned her earlier assumption that a substitute for love is admiration and recognition and that one can earn them solely by giving up all pleasures in favor of learning and constantly striving for success. Remaining in a state of cognitive-emotional dissonance, when she questioned the universality of the adaptive schema she had hitherto used (basic conflict), i.e., success = love, she opened herself to new possibilities. During this time, she began to recall everyday experiences that were surprising to her, which did not correspond to her previous assumptions and became more attentive to events in the therapeutic relationship that challenged her rigid beliefs and views. As it turned out, this was a time of transformative experiences for her and a cessation of her disease symptoms.

Conclusions

Depressive disorders, despite their complex etiology, are amenable to psychotherapeutic interventions. They undoubtedly require a comprehensive approach and multi-specialist cooperation. PPT has developed its conceptualization of depressive disorders in the sense of their etiology, triggers and maintenance factors, and treatment methodology. The treatment process includes three consecutive stages of differential analysis with appropriately tailored therapeutic interventions.

1) Disease symptoms, which includes:
   a) learning about symptoms in the context of the patient's life;
   b) positive reframing;
2) Psychodynamic conflicts including:
   a) current conflict;
   b) basic conflict;
   c) inner conflict,

and on the self-esteem regarding:

- perception;
- affect regulation;
- emotional communication;
- attachment styles.

3) Target symptomatic experiences and its reconstruction (transformative experience).

Finally, it is worth emphasizing that depressive disorders develop in a socio-cultural-historical context. For this reason, in the process of diagnosis and treatment, it is necessary to consider all those conditions that contribute to the appearance of depression, its presence, and its resolution.

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